

This benefit summary is intended to help you compare coverage and benefits and is a summary only. For a more detailed description of coverage, benefits, and limitations, including any related exclusions not contained in this benefit summary, please contact the health care service plan or health insurer and consult the individual plan's evidence of coverage. The comparative benefit summary is updated annually, or more often if necessary to be accurate. The most current version of this comparative benefits summary is also available on the DMHC's website, www.dmhc.ca.gov. You may contact the Department of Managed Health Care at (888) HMO-2219 for further assistance regarding the matrix.

Plan Name Blue Shield of California HMO Post MRMIP Graduate Product	Plan Contact Phone Number IFP Customer Service 1-800 431-2809
Coverage summary Eligibility requirements.	<p>You are eligible to enroll in the Post-MRMIP Graduate Product if you meet any of the following criteria:</p> <ul style="list-style-type: none"> · Apply for coverage within 63 days of the termination date of previous coverage under the MRMIP and have had continuous coverage under the MRMIP for a period of 36 consecutive months, or · Have been enrolled in a Post-MRMIP standard benefit plan and move to an area within the state that is not in the service area of the plan or insurer you previously selected and you apply for coverage within 63 days of termination of previous coverage, or · Have been enrolled in a Post-MRMIP standard benefit plan that is no longer available where you reside and apply for coverage within 63 days of the termination date of the previous coverage · Plans may decline coverage if you are eligible for Parts A and B of Medicare at the time of application and are not enrolled in Medicare solely due to end stage renal disease. <p>Dependent Coverage-The following dependents may also be enrolled:</p> <ul style="list-style-type: none"> ·Subscriber's spouse ·Subscriber or spouse's unmarried children ·Dependent children over age 23 incapable of self-sustaining employment due to certain disabilities. <p>(Consult the Plan's Evidence of Coverage for further information as availability of dependent coverage varies).</p>
The full premium cost of each benefit package in the service area in which the individual and eligible dependents work or reside	Premiums charged by plans vary by region and age of subscribers. See Post-MRMIP Graduate Product Rate Chart on this website.
When and under what circumstances benefits cease	<p>Coverage may be terminated by the Plan under the following circumstances:</p> <ul style="list-style-type: none"> · Loss of eligibility by Subscriber or enrolled dependents, including (1) Subscriber or Dependent(s) move out of the Plan's service area (Please contact the Plan for further details regarding the process for selection of a different Post-MRMIP Graduate Product under such circumstances) or out of California or (2) Enrolled dependents no longer meet eligibility requirements. · Termination of Plan type by Plan in which Subscriber or Dependents is enrolled (Please contact the Plan for further details regarding the process for selection of a different Post-MRMIP Graduate Product under such circumstances.) · Non-payment of subscription charges. · Fraud or material misrepresentation. <p>(This list represents a general summary. Please consult the Plan's Evidence of Coverage for specific details regarding causes for termination by the Plan.)</p>
The terms under which coverage may be renewed	<p>Coverage under the Plan shall continue, except under the following circumstances:</p> <ul style="list-style-type: none"> · Loss of eligibility by Subscriber or by enrolled Dependents · Non-payment of subscription charges · Fraud or material misrepresentation · Termination of plan type by Plan in which Subscriber or Dependents is enrolled (Please consult the Plan for further details regarding the process for selection of a different Post-MRMIP Graduate Product under such circumstances.) · Subscriber moves out of the service area.

Other coverage that may be available if benefits under the described benefit package cease	No other coverage is available.
The circumstances under which choice in the selection of physicians and providers is permitted	Members are encouraged to choose a primary care Plan Physician from a list of available Plan Physicians in the following specialties: internal medicine, obstetric/gynecology, family practice, and pediatrics. Members may change their primary care Plan Physician at any time.

Coverage Summary

Lifetime and annual maximums	Lifetime Maximum: \$ 750,000 Calendar Year Maximum \$ 200,000
Deductibles	None

Benefit Summary (*1)		Co-payments Calendar Year Copayment Maximum \$2,500/ covered person \$4,000/family	Limitation
Professional Services	Physician office and specialist visits	\$15 per visit \$30 per Access+ Specialist visit	
Outpatient Services	Outpatient services, including, but not limited to surgery and treatment, and diagnostic procedures. Outpatient renal dialysis Laboratory, X-ray, and Major Diagnostic	\$15 per visit or surgery No charge No charge	
Hospitalization Services	Inpatient services, including, but not limited to room and board and supplies. Physician Inpatient Services	\$200 per day No charge	
Emergency Health Coverage	Emergency room services at contracted and non-contracted facilities for medically necessary emergency services.	\$25 per visit	Emergency room. The copayment is waived if the subscriber is admitted directly to the hospital as an inpatient.

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Benefit Summary Cont.		Co-payments	Limitation
Ambulance Services.	Emergency ambulance transport.	No charge	When medically necessary. Includes both surface and air services.
Prescription Drug Benefits.	Medically necessary drugs prescribed by a physician.	<p>Formulary Generic Drugs: \$10</p> <p>Mail service Formulary Generic Drugs: \$10</p> <p>Formulary Brand Drugs: \$15</p> <p>Mail Service Formulary Brand Drugs: \$20</p> <p>Home Self-Administered Injectables: 20% of negotiated pharmacy contracted rate up to a maximum of \$100/prescription</p> <p>Non-formulary drugs are not covered unless approved as medically necessary through Blue Shield's prior authorization process. If a non-formulary drug is prior authorized, coverage is provided at the same copayments noted above.</p>	<p>Non-Participating Pharmacies are not covered except for emergency cases and drugs for emergency contraception.</p> <p>Injectable Drugs, other than Home Self-Administered Injectables, are excluded.</p> <p>Contraceptive implants are excluded</p> <p>Outpatient Prescription Drugs are limited to a quantity not to exceed a 30-day supply</p> <p>Mail Service Prescription Drugs are limited to a quantity not to exceed a 60-day supply</p>
Durable Medical Equipment.	Home medical equipment, including, but not limited to, oxygen, parenteral and enteral nutrition, colostomy and ostomy supplies, corrective prosthetics and aids, orthoses, and diabetic supplies.	20%	No benefits are provided for wigs, orthopedic shoes and other supportive devices for the feet (except for diabetes), home testing devices, environmental control equipment, generators, self-help/educational devices, exercise equipment, or any type of speech or language assistance devices, or any other equipment not primarily medical in nature.
	(Some items listed above may be covered under other benefit categories.) Surgically implanted devices and supplies	No charge.	

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Mental Health Services.	Inpatient and outpatient mental health services, including, but not limited to, mental health parity services (**2) for serious mental disorders and severe emotional disturbances for children.	Inpatient Hospital and Professional (Physician) Services for Severe Mental Illnesses or Serious Emotional Disturbances of a Child \$200 per day	
		Inpatient Hospital and Professional (Physician) Services for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child \$200 per day	10 days maximum per calendar year.
		Psychiatric Partial Hospitalization for Severe Mental Illnesses or Serious Emotional Disturbances of a Child \$200 per episode of care	An episode of care is the date from which the patient is admitted to the Partial Hospitalization Program to the date the patient is discharged or leaves the Partial Hospitalization Program. Any services received between these two dates would constitute the episode of care.
		Outpatient Psychiatric Care for Severe Mental Illnesses or Serious Emotional Disturbances of a Child, Initial Visit \$15 per visit \$30 per Access+Specialist visit	Intensive outpatient care is covered under this benefit.
		Outpatient Psychiatric Care for other than Severe Mental Illnesses or Serious Emotional Disturbances of a Child \$15 per visit \$30 per Access+Specialist visit	15 visit maximum per calendar year. This visit maximum includes Mental Health Services Access+Specialist visits. Intensive outpatient care is not covered under this benefit.
		Psychological Testing: No charge	All Mental Health Services Access+Specialist visits require a \$30 copayment per visit.
Residential Treatment.	Transitional residential recovery services.	Not Covered	
Chemical Dependence Services.	Medically necessary inpatient substance abuse medical detoxification is covered.	\$200 per day	
Home Health Services	Home health and home hospice care services (***3)	\$10 per visit	Home Health Care: 100 visits maximum per calendar year.
Custodial care and skilled nursing facilities.	Skilled nursing care and skilled nursing facilities services.	\$ 50 per day	This benefit is limited to 100 days maximum per calendar year, except when received through a Hospice Program provided by a Participating Hospice Agency.
	Custodial care	Not covered	

(**1) For participating providers, percentage co-payments represent a percentage of actual cost, or, if the plan pays the provider a per-member-per-month rate, an equivalent cost. Percentage co-payments for services provided by non-participating providers are a percentage of usual, customary or reasonable rates, negotiated costs, or billed charges, as determined by the plan. (Please consult the Evidence of Coverage). In a PPO, enrollees are also responsible for any excess amount billed by a non-participating provider.

(**2) Health Plans in California are required by law to provide certain mental health services according to the same terms and conditions as other similar medical benefits. Please contact the individual plan for further information regarding the conditions subject to mental health parity.

(***3) Hospice benefits are available through the plan. Please consult the plan's Evidence of Coverage.